2523 14 ¾ Avenue
Rice Lake, WI 54868
715.859.6670 phone
715.859.6669 fax
naturesedge@citizens-tel.net
www.naturesedgetherapycenter.org

PLAY GROUP
PATIENT HISTORY AND PARTICIPATION AGREEMENT

To be completed by the patient or parent/legal guardian

GENERAL INFORMATION

Patient's Last Name: _____ First Name: _____
Date of Birth: _____ Age __ Height: _____ Weight: _____ M F
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Alternative Phone: _____

Employer/School: _____
Address: _____
City: _____ State: _____ Zip: _____
Supervisor/Teacher: _____ Phone: _____

Parent/Legal Guardian: _____
Address (if different from above): _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Alternative Phone: _____
Secure Email Address: _____

Referral Source: _____

How did you hear about Nature's Edge? _____
_____
_____

THERAPY HISTORY

Is the patient <u>currently</u> receiving *any* therapy services (physical, occupational, or speech therapy services) at any location (school, private clinic, county, etc)? □ Yes □ No
If "yes" please tell us where and who the therapist is: _____
_____

Has the patient had therapy (physical, occupational, or speech therapy) in the past? □ Yes □ No If "yes", please tell us where, when, and who the therapist(s) was: _____

_____

_____

_____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Yes	No	Comments
Vision	___	___	_____
Hearing	___	___	_____
Sensation	___	___	_____
Communication	___	___	_____
Heart	___	___	_____
Breathing	___	___	_____
Digestion	___	___	_____
Elimination	___	___	_____
Circulation	___	___	_____
Emotional	___	___	_____
Behavioral	___	___	_____
Pain	___	___	_____
Bone/Joint	___	___	_____
Muscular	___	___	_____
Thinking/Cognition	___	___	_____
Allergies	___	___	_____

What medications is the patient currently taking, including over-the-counter medications? _____

_____

_____

Describe your abilities/difficulties in the following areas, including assistance required or equipment needed:

FUNCTION (i.e., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____

_____

_____

_____

_____

_____

SOCIAL (i.e., work/school including grade completed, leisure interests, relationships-family structure, support systems, companion animals, fears/concerns, etc.)

_____

_____

GOALS (i.e., Why are you/the patient applying for treatment? What would you like/the patient to accomplish?)

PARTICIPATION AGREEMENT

I, _____ (Patient's/Parent's/Guardian's Name), hereby agree that I will attend prescribed therapy sessions with the patient (or assign a consistent caregiver to do so) and will be responsible for implementing the home program and strategies as recommended by the therapist(s) in order to facilitate progress toward the patient's goals.

a) In order for your therapist to provide the best possible treatment for the patient, it needs to be understood that patient/caregiver cooperation and participation with a "home program", "carryover program" or "recommendations" be followed and charted/documented in the home setting in order to determine measurable benefits of the program or the need to modify a treatment strategy.

b) In order for your therapist to provide the best possible treatment for the patient, it also needs to be understood that the patient/caregiver must cooperate with Nature's Edge in attending prescribed, regular treatment sessions.

Your signature indicates that you authorize the release of the patient's medical information to Nature's Edge Therapy Center, Inc. and for Nature's Edge Therapy Center, Inc. to release the patient's medical information for professional purposes (upon written notice to the business office you may inspect or receive copies of such medical information upon payment of copying costs), and you authorize therapy to be provided in the presence of others who may not be directly involved in the provision of treatment. The patient's case is confidential and will not be discussed openly.

Your signature further indicates that you understand this is not a Medicaid covered service and that you will be paying privately.

Signature of Patient, Parent or Legal Guardian

Date

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RELEASE FORMS

REGISTRATION AND GENERAL RELEASE FORM

I, _____(Patient's/Parent's/Guardian's Name), hereby apply for participation in Nature's Edge Therapy Center, Inc.'s therapy program. I acknowledge the risks and the potential for risks of the program's use of horses and other animals. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs and assigns, executors or administrators, all claims for damages against Nature's Edge Therapy Center, Inc., its therapists, instructors, aides, volunteers and /or employees, and the Lundeen Ranch, of any and all injuries and /or losses the patient, patient's family or guests may sustain while participating in the therapy program.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

PHOTO RELEASE

I consent to and authorize the use and reproduction by Nature's Edge Therapy Center, Inc. of any and all photographs and any other audiovisual materials taken of the patient, patient's family, or guests while in treatment for use in promotional materials, educational activities, exhibitions, or for any other use for the benefit of Nature's Edge Therapy Center, Inc.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

HELMET RELEASE

I, _____(Patient's/Parent's/Guardian's Name), hereby give permission for Nature's Edge Therapy Center, Inc.'s therapists to forego the use of a helmet for _____(patient's name) when necessary to prevent any distractions from therapy goals. I acknowledge the risks and the potential for risks when not using the helmet when on a horse. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs and assigns, executors or administrators, all claims for damages against Nature's Edge Therapy Center, Inc., its therapists, instructors, aides, volunteers and /or employees, and the Lundeen Ranch, of any and all injuries and /or losses the patient may sustain while not wearing a helmet.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

DAMAGE AGREEMENT

I, _____ (Patient's/ Parent's/Guardian's Name), hereby agree that I will be responsible for seeing that any children, guests, or animals brought by me on the premises of Nature's Edge Therapy Center, Inc. are properly supervised at all times while on such premises. I further agree that I will be liable for any damage to the property of Nature's Edge Therapy Center, Inc. or the Lundeen family, while on the premises of Nature's Edge Therapy Center, Inc., or in the Lundeen home, and/or for any loss of use of such property resulting from any such damage, caused by my negligence or that of any child, guest, or animal brought on such premises by me. I further agree to pay for any necessary repairs or to reimburse Nature's Edge Therapy Center, Inc. and/or the Lundeen family for the reasonable cost of repair, replacement, and/or loss of use of such property pending repair or replacement.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Consent Plan
In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services from, or while being on the property of, Nature's Edge Therapy Center, Inc., and the above cannot be reached, I authorize Nature's Edge Therapy Center, Inc. to:

- Secure and retain medical treatment and transportation if needed.
- Release patient records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes X-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date: _____
Patient, Parent or Legal Guardian

Non-Consent Plan
I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services from, or while being the property of, Nature's Edge Therapy Center, Inc. In the event emergency treatment aid is required, I wish the following procedures to take place:

_____
_____
_____
_____

Non-Consent Signature: _____ Date: _____
Patient, Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.

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PATIENT INTEREST SURVEY

Name: _____
Age: _____ Date: _____ Grade Level: _____
School you attend: _____

What are your hobbies? _____

What do you hope to accomplish during therapy? _____

What activities are you most interested in participating in? _____

What is your favorite animal? _____

What, if any, previous experiences have you had working with large and/or small animals?

What, if any, previous experiences have you had with gardening and/or landscaping projects?